# FINANCING MONTANA'S HEALTH CARE

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Bureau of Health Planning and Resource Development
Division of Hospital and Medical Facilities
Department of Health and Environmental Sciences

## Introduction and Background Information

The major health issues facing Montana in 1982 are financial issues. The health of our citizens and the availability of health care services is continuing to improve. The 1981-82 Montana State Health Plan reports that the state compares favorably with the rest of the nation in most major diseases and infant mortality rates. Only those problems with origins outside the scope of the health care system are really more serious here than elsewhere. Montana's rate of accident and alcoholism-related disease, disability and death are higher than the corresponding rates in many other states.

Current health status levels and availability of health services have been reached through rapid growth in the health care industry and increasing support from state and federal governments. Services to the poor, handicapped and elderly constitute a major portion of the government participation. These are thus the populations most threatened by reduction in public health budgets. Since our health facilities also have become increasingly dependent on government funds, the availability of services to everyone is also threatened, particularly in sparsely-populated areas with financially marginal facilities.

Because of government's substantial financial commitment and the potential for impact on all citizens, health policy is one of the most important issues for state government in Montana in 1982.

Listed in the following section are six major issues and a possible approach to each one. The recommendations listed here are selected as examples of potential state actions to address major health care issues.

## Montana's Health Care Budget

### The Issue

A rational health services budget should be based on health policy, instead of policy being dictated by budget considerations. When resources are more than adequate for health needs, budgets can be made on an item-by-item basis. The need for state participation can be determined and funded with minimal concern for priorities among programs. When unmet needs are identified they can be handled by the state using state or federal funds.

Although national health policy in recent years has not been formally stated, it has effectively been one of assuming all Americans have a right to quality health care. "Quality care" is generally considered to mean whatever can be provided by the current "state-of-the-art." Through the 1970's this policy was generally implemented using a program-by-program budgeting approach.

Conditions have changed due to inflation, advanced medical technology and federal fiscal policy. There will no longer be sufficient funds to cover all possible health care services if the recent increases in the cost of these services continue. It is now necessary to weigh expenditures for health care against those for welfare, highways, environmental protection, law enforcement and other state programs that are equally necessary for the health and well-being of Montanans.

The rate of increase of health care expenditures cannot be maintained, and continued funding for current service levels will be increasingly difficult. A rational health care budget now requires a critical evaluation of each program to establish its relative need and importance. Budget priorities should be derived from an explicit, comprehensive state health policy.

The first tool needed by state government in the determination of health policy is a thorough, objective evaluation of health needs and priorities. Our system for determining state health budgets does not need to be changed, but the decision makers need more information to carry out the responsibility of allocating limited health resources.

### Recommendations

A formal system for evaluating state health expenditures should be established. Most of the necessary information is already being used by the various state agencies in their budget request preparations. The added steps in this process would be:

(1) to develop a standard set of information requirements and a format for their presentation;

(2) to perform an objective review of this information to assure reasonably consistent information, sources and the reliability and validity of data.

One possible way to do this without additional funding or creating new government agencies would be to assign this task to the Statewide Health Coordinating Council. The Council could work with the Departments of Social and Rehabilitation Services, Health, and Institutions and the Governor's staff to perform both of the above functions.

First, information requirements could be established so an objective evaluation could be made of each program. These requirements would include such information as the health conditions addressed by the program, the number of people affected, the age, sex, and race of people receiving services, the seriousness of the health condition, the consequences of reduced or increased state participation, and other criteria to help establish priorities.

The second phase would involve receiving the information from the departments, checking for consistency in information (population counts, resources available, etc.) and verifiability of data (concrete data versus estimates, consistency with other sources, etc.). The information would then be assembled in a form that would allow comparison, including current funding from all sources and budget need estimates.

The final report could be used by the Governor's Office and the Legislature in allocating funds for health services. The report would not contain all the necessary information for priority-setting, since there would still be value judgements, historic commitments, policy positions of public officials and other relevant considerations. Such an approach would, however, provide a common informational basis for the making of these key decisions.

## Paying for Health Facility Growth and Renovation

### The Issue

Health care facilities must be reimbursed for legitimate capital investment, interest, and administrative costs, regardless of their utilization level. The development of excess capacity encourages over-utilization and increases the unit cost for all services delivered. Unit cost is also influenced by a facility's design. If a nursing home or hospital can be adequately built for less investment, or can be designed to use labor and equipment more efficiently, these efficiencies can be reflected in the price of each service.

Excess or unnecessarily expensive facilities simply mean more choices or more elegant, if not better quality, care when there are no financial constraints. The current situation in Montana is not one in which this luxury can be afforded.

In 1980, Montana hospitals used 33 percent of our health care funds, and nursing homes, the fastest growing sector of health care expenditures, used 12.9 percent. Combined, federal and state funds account for 41 percent of the reimbursement of hospitals and 68 percent of the reimbursement of nursing homes. County and city funds are also used in some facilities in Montana. If limits are placed on government expenditures for health, the result will be a decrease in services as the prices of those services increase. Increased service costs also will increase the number of people requiring assistance in paying for their health care.

### Recommendations

Regulation is not a popular or desirable solution to most problems. The Certificate of Need program has suffered from federal requirements that do not fit the needs of many states. Its shortcomings have been due mainly to a cumbersome review process and federal requirements for plans which do not provide clear policy for decision-making. These and other problems have resulted in the community-based Health Systems Agency and the Department of Health and Environmental Sciences finding it difficult to recommend disapprovals of certificates. While the Health Systems Agency's subarea councils and executive committee include, by law, a majority of consumers, the decisions of these groups are consistently shaped by health care providers who dominate the often uninformed consumers and push favorable review decisions through the hearing process.

The positive effect of Certificate of Need has been to increase public knowledge of health care facility expenditures and encourage more comprehensive planning by health care facilities.

The Certificate of Need process could be improved by developing more comprehensive plans, with more clearly stated policies, particularly with

respect to expenditures. There should be less reliance on federal resource standards and more emphasis on actual needs in Montana. On the review side, the process should be shortened, more comprehensive records should be developed, thresholds for review should be changed, and all decisions should be consistent with specific and detailed planning policies. Major capital projects should be evaluated only on the basis of their need and the soundness of their financial and overall planning, not on the basis of political pressures and influences that are often decisive.

Future plans would represent policies and standards set by a consensus of Montana health care providers, consumers, and public officials. Their enforcement would constitute a rational allocation of Montana's health care resources, not an external constraint on facility development.

## Certificate of Need and a Shrinking Budget

### The Issue

The state Medicaid budget is established for a two-year period on the basis of projected service needs and costs. Currently, there are difficulties because of the proposed expansion or renovation of some hospital and nursing home facilities. These capital expenditures often result in increased service utilization, and increased costs for Medicaid patients.

The Medicaid program is faced with a number of undesirable alternatives. Eligibility could be restricted, which would keep some people from getting the health services they need. Services could be reduced for currently eligible Medicaid patients. Medicaid payments to providers could be reduced to a smaller share of full charges, which would result either in the Medicaid patient covering a portion of the cost or in shifting the costs to third-party payers. There is also the rather unrealistic alternative of seeking additional appropriations.

One solution that has been proposed is to use the Certificate of Need process to prevent expansion or renovation of facilities except when approved in conjunction with the state's budget determinations.

Such a change would result in converting the basis for decisions in the Certificate of Need program from community need for health services to purely budgetary requirements. This would make the CON review process a very expensive enforcement mechanism for financial judgements made by the Department of SRS. A moratorium on all capital expenditure projects, no matter how distastful for those involved, would be far more simple and efficient. If it is decided that the Medicaid budget cannot allow further expansion or renovation projects, then the best approach would be to say "up front" that no capital projects will take place until July 1, 1983, except in cases of facilities which have code deficiencies or pose life-threatening conditions for patients and staff.

The Medicaid budget is sensitive to increases in the cost and volume of hospital and nursing home services. Medicaid funds for 1980 in Montana were spent at a level of $29.4 million (55 percent of all Medicaid expenditures) for nursing home services and $14.0 million (22 percent) for hospitals. Hospital and hospital-related physician services paid by Medicaid were $21 million (33 percent) in 1980. It must also be noted that Medicaid payments were 65 percent of the total revenues received by nursing homes and only six percent of the total revenues received by hospitals in 1980.

Restriction of service volume or the maintenance of sub-standard facilities to protect the Medicaid budget will affect the quality of care for all hospital and nursing home patients, regardless of the source of payment for their care.

The federal government is planning to take over full responsibility for the Medicaid program in the future. It is almost certain that limits will be placed on payments and the counties in Montana will be responsible for paying for medical services for indigents who are not covered or services only partially covered by Medicaid.

Clearly there is need for a health care financing system that permits accurate budgeting by Medicaid, Medicare, private insurance carriers and other payment systems as well as by the health care institutions themselves. It is becoming increasingly likely that trade-offs between service needs and limited resources will become necessary. It also seems evident these trade-offs cannot be made in a rational manner by a system in which budget constraints and service needs are confused.

## Recommendations

The Certificate of Need program should be redesigned and maintained as a means of establishing community consensus on the number and types of health care facilities needed in Montana. If this remains the primary objective of the program, it cannot also be used to limit state Medicaid expenditures.

The state could set up a system in which rates and a maximum allowable volume of services for Medicaid payments would be negotiated for each budget period and not changed. While this arrangement would protect the Medicaid budget, it would definitely lead to cost shifting to other payers and result in Medicaid patients being unable to always obtain services in the most convenient facility.

One alternative used in other states to deal with this problem is a mandatory prospective rate system. A formal process can be established for negotiating rates for services in each hospital. These rates would remain in effect for one year, and would be the basic charge paid by all purchasers of services.

A prospective rate system could include provisions for emergency repairs or construction, but most capital expenditures could not be used as a basis for rate increases until the next yearly rate was negotiated.

This kind of system would require some provision for the fact that state budgets must be established for two years. It would also require an accurate projection of the volume of services needed by Medicaid recipients. The system would, however, give hospitals, the state and other third-party payers a much more stable budget throughout each year.

The potential value of a prospective rate setting process varies from state to state, and the particular design must fit the unique needs of the state. According to an article in the January 4, 1982 issue of "Washington Report on Medicine and Health", Congress is considering reducing the cuts in Medicaid funding to states from four percent to three percent for states with "qualified hospital cost review programs." There seem to be enough potential gains to merit further consideration of a mandatory rate setting system for Montana.

## Paying for Long-Term Care

### The Issue

Long-term care for elderly, chronically ill, mentally ill, and developmentally and physically disabled persons is the area of health care most heavily dependent on government financing. Nursing homes in Montana received 65 percent of their revenue from government sources in 1980.

Among the many problems frequently coming to public attention in long-term care are:

1. Lack of service alternatives
2. Problems with quality of care
3. Funding shortages
4. Proximity of service to home
5. Need for swing beds (Beds used for hospital or long-term care services.)

The first of these is further complicated by the considerable overlapping of the social and health care needs of long-term care recipients. Each of the patient groups mentioned has individuals whose needs vary from limited personal care to constant nursing and medical attention.

One likely outcome of these need differences is a system which offers only the extremes, either the highest level of service or none. Thus, a person might do without care up to the point where a nursing home placement is necessary as the only alternative. This is likely to occur in sparsely-populated areas or when limited resources must be allocated over a wide range of services.

Funding shortages and quality of care problems are both being addressed by government and health care providers. Service alternatives are less directly addressed because of the fragmentation of service delivery and funding.

Day care, home health care, personal care homes, group homes, and other social and medical long-term care services are usually unable to survive without government support. The dependent nature of their clients usually results in an inability to support themselves financially. Most of the recipients of these services also have limited choice concerning which services will be used to meet their needs.

Cost of care, quality of care, and appropriateness of services are most favorable when a full range of services is available. However, a full range of services costs more than limiting and rationing services. The later approach is currently favored in current federal government policy. While states are free to supplement the limited federal programs, they do not really have the resources to do so.

Recommendations

The state government of Montana, with as much public participation as possible, should realistically assess long-term care needs and resources and develop policy for use of those resources. The importance of this assessment and policy development for long-term care can be illustrated by the projected statewide deficit of nursing home beds by 1985.

The following are examples of questions that should not be decided indirectly through inaction or budget expediency:

1. Should the state license and support personal care homes for persons requiring assistance in daily living but not continuous medical or nursing care?

2. Are home health services financially feasible? If not, are they desirable anyway? Should such services be publicly supported if they are only feasible in more populated areas?

3. Is the social desirability of having long-term care available near one's home greater than the medical and financial advantages of more specialized long-term care services which will necessarily serve larger areas?

4. Can social and welfare programs be better coordinated with health programs so that an individual's needs and eligibility are consistently assessed by both systems? The goal would be to set up a system in which neither the individual recipient nor the government agency with budget responsibility would benefit from improper long-term care placements.

5. Should multi-service institutions or closer medical monitoring be used as a means of improving service access and appropriate placement?

These and other long-term care issues should be addressed by state government and studied in an integrated evaluation of long-term policy for the development of long-term care in Montana. These decisions should not be left up to the fragmented long-term care industry or to government operating agencies that must carry out the policies of elected officials with the budgets they are assigned.

Regardless of the policy decisions reached through an evaluation of the questions raised above, the recommendations provided in the long-term care component of the 1981 State Health Plan regarding the following areas should be addressed:

A. Certificate of Need programs should remain in effect as a method of negotiating and enforcing consensus on nursing home and lower-level residential services bed need.

B. Certificates of Need should only be approved for remodeling, replacement, or addition of nursing home and lower-level residential services beds that meet the conditions expressed in the recommendations.

C. Non-institutional long-term care services should be developed at least to the level determined by the 1980 SRS State Plans.

D. Local development of services through technical assistance and removal of regulatory and reimbursement barriers to formation of multi-service institutions (including swing bed arrangements) or agencies should be encouraged.

## Promoting Health and Preventing Disease

### The Issue

Our modern health care system gives priority to the diagnosis and treatment of acute conditions, particularly those that are life-threatening. Some of the causes of this bias towards life-threatening diseases are quite reasonable. The urgency of the demand for such care is a primary factor. A less direct influence is the fact that our most thorough data on the health of the population is derived from death certificates. Consequently, our need assessments often over-emphasize diseases that are direct causes of death.

The priority health problems selected for this year's Montana State Health Plan are (1) alcohol abuse and alcoholism, (2) accidents and suicides, (3) cancer, and (4) hypertension. These were selected mainly on the basis of mortality statistics, estimated prevalence and potential for intervention.

The State Health Plan also shows that medical and other health care responses to these conditions are being carried out and improved. The most impact could be gained through prevention. Disease prevention, however, does not replace treatment but must be pursued in addition to necessary treatment.

Health promotion and disease prevention programs are believed to be effective for many diseases. The results, however, are usually long-term and only detectable through indirect measures. It is difficult to prove the cause of the absence of a disease or disabling condition. In a time of tight money it is difficult to support smoking clinics, nutrition programs and health education when funds for treatment of renal failure, lung cancer or cirrhosis of the liver are barely adequate.

Alcohol problems have continued to increase although treatment programs have improved and increased. Prevention programs have not had significant impact. Alcohol is not only considered one of the most serious health problems in Montana, but is also a major contributor to accidents, which is also one of the major threats to health in the state.

Immediate demand for treatment cannot be ignored. On the other hand, if preventive measures are not continued the growth in demand for treatment can be expected to far exceed the short-term gains of discontinuing these activities.

### Recommendations

The sources of health promotion and disease prevention services differ depending on one's income level. Those with resources obtain these services mainly from private physicians; those without rely on public health programs. Services directed toward the society as a whole, rather than delivered to individuals, are almost exclusively provided by government and charitable institutions.

Cuts in government programs can thus be expected to reduce access to personal preventive services for the poor and elderly and access to health promotion and environmental health programs for everyone.

Long-term solutions to these problems have the best chance of being effective if they bring about a better balance of health care services from all sources, which is preferable to government taking exclusive responsibility for health promotion. Government policy should include health promotion and education services for those who receive all or most of their health care from government sources. This, in fact, is the traditional approach of public health care, particularly public health nursing.

The remainder of the population should obtain these services from the same health care providers and payment systems that furnish their other health care. This cannot be expected to occur spontaneously as a result of government withdrawal from health education disease prevention and health promotion. A more productive approach would be to use government influence and resources to develop health promotion services through existing health care providers and community organizations. Employers, unions, farmers' organizations, community recreation facilities, hospitals, and physicians' offices are increasingly becoming involved in programs to promote health. Government policy would be most effective if resources were shifted from direct delivery of promotion and education services to promoting their integration with the health care systems already in place in each local community.

Alcohol programs are the one area where prevention probably can only be effective when directed to persons already affected by the problem. Prevention is thus integrated with treatment. It thus seems evident that treatment programs directed toward youth would have the greatest potential to have impact and would produce the most positive long-term effect. Alcohol treatment for youth should be a priority for use of state alcohol treatment funds.

## Health Care Cost Containment

### The Issue

Attempts to contain health care costs in recent years have not been particularly successful. Usually, they have not been cooperative efforts. Government has used regulation. Health systems agencies have relied more on their project and grant review functions than their educational and health promotional activities. Unions and employers have worked towards their own financial advantage rather than towards the development of cost-effective systems.

Insurance plans are pre-payment systems which insulate us from the direct costs of the health services we use and offer no penalties to discourage over-utilization of services. The same problems are inherent in the government's insurance programs for the poor and elderly.

Hospitals have three different interest groups directly involved in their overall management. The administration manages the business side, the medical staff is responsible for patient care, and the board of directors establishes policy. Nurses, aides and other technical and non-technical staff may have some limited voice in the hospital's operation. Other voices with an increasing impact on hospital operating policies are those of the major purchasers of health services, insurance carriers, and government.

These latter groups have been seen as consumer representatives, but they have not always played that role. Private insurance groups are frequently dominated by health care providers and are pressured by consumers to maximize coverage. Government payers often are not knowledgeable about health care needs and issues, and make decisions in response to the influence of pressure groups or budgetary considerations.

The causes of health care cost increases are complex and constantly debated. The trends, however, are clear and describe a crisis situation for consumers, government and health care providers:

1. Nationally, personal health care costs have nearly doubled every five years since 1965. Figure 1 presents expenditure amounts and sources of increases.

2. Health care expenditures are consuming an increasing proportion of our overall resources. Table 1 shows health care expenditures for selected years since 1950. The increase has been from 4.4 percent of the gross national product to 9.4 percent in 1980.

3. Institutional services, hospitals and nursing homes are consuming an increasing proportion of health care expenditures. They have gone from 31.9 percent of our expenditures in 1950 to 48.7 percent in 1980. Table 2 provides a distribution of expenditures by source for selected years since 1950.

4. Government expenditures have risen to about 40 percent of health care expenditures and direct payments have dropped to only about 30 percent of the total. (See Table 3) Table 4 gives sources of funds for various kinds of care and gives some indication of how government spending has influenced the growth of services. Table 5 is a comparison of Montana and national distribution of health care expenditures. While there are some variations, the general situation is similar in Montana.

5. Growth of Medicaid expenditures has more than doubled from 1977 to 1981. Figure 2 shows Medicaid and Medicare increases in recent years.

The current situation is a drastic change in the financing side of these trends. Federal government spending for health care is being reduced in some areas and held constant in others. Costs and cost increases will thus shift to direct payment or to the states in some cases and services will be reduced in others. For the first time in about 30 years, health care resources are limited and resource allocation and cost containment are essential to the maintenance of adequate health care services.

Recommendations

1. The most desirable cost containment method is to reduce the need for services. Effective health promotion programs, particularly those directed to youth, should be maintained. This approach cannot reduce the current demands, only retard their growth.

2. Regulatory programs should be minimal, but as long as government financing is a major factor in health care financing there must be mechanisms to limit the contributions of these programs to cost escalation.

   Certificate of Need, rate regulation, and other mechanisms for control of expenditures must be carefully evaluated for their current benefits and costs in Montana.

3. Government must enlist the physician community into a leadership role in making the most effective use of our limited and expensive health care resources. A recent Journal of the American Medical Association article examines a variety of programs for cost containment in medical care. Physicians generate an estimated 80 percent of all health care expenditures. The most effective programs to involve physicians in cost containment were those built around incentives and education, not those with punitive and regulatory features.

   Montana state government needs two kinds of direct involvement with physicians. The first is a mechanism for a formal advisory role on state policy by the physician community. The second is a program of education for physicians in cost containment techniques.

One possibility for obtaining this involvement would be a health care cost containment program operating out of the Governor's Office. This program would have a director answering to an advisory panel consisting of the Directors of Social and Rehabilitation Services, Institutions, and Health and Environmental Sciences and four representatives of the state's physician community.

The program would have the following responsibilities:

A. Provide public officials with more and better information concerning the effects of their health policy decisions.

B. Educate hospital boards and city and county commissioners about their role in representing their committees' needs and resources.

C. Provide physicians with information about the cost of the services they order that are delivered by others (hospital services, nursing home services, therapy, drugs, etc.).

D. Increase physician familiarity with the use of long-term care alternatives.

E. Provide physicians with information about the most cost-effective means to accomplish medical objectives.

Conclusions:

Health care costs have reached a level where both cost containment and resource rationing actions are necessary. Government funding has become a major factor in the provision of health care for a considerable portion of the population. This near-crisis situation in health care funding and the changing roles of federal and state government in the funding and regulation of health care delivery make state health care policy a major concern in 1982.

Montana state government must establish and implement policies that will maintain needed health services for Montana residents within a realistic expenditure limit. State Medicaid expenditures and county health care expenditures for the indigent must be stabilized. Health promotion and disease prevention services must be maintained and growing needs for alcoholism treatment and long-term care for the elderly must be met. These challenges require careful planning by government and active participation by health care providers so that government delivery and regulation of services can be minimized.

There are a number of specific actions Montana's government can take to address immediate problems and prepare for longer-range developments in the financing of health care. The Department of Health and Environmental Sciences should prepare a bill to submit to the 1983 Legislature to revise the Certificate of Need Law to make it a more appropriate tool for planning and regulating capital expenditures. The Department of Social

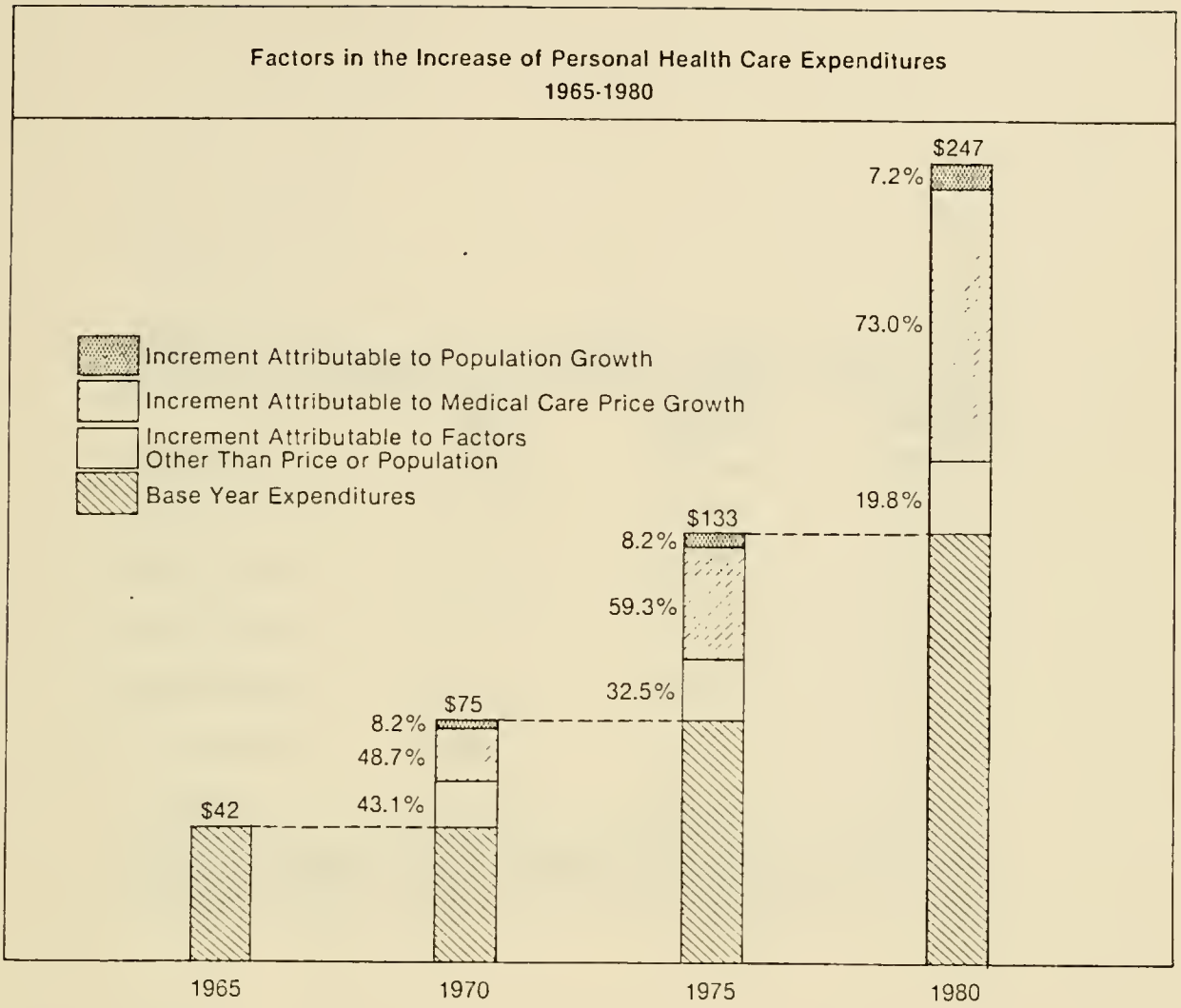
and Rehabilitation Services should evaluate methods of stabilizing health care budgets for state and local government, the public, and health care institutions in Montana. Rate regulation, revised reimbursement systems and competition promotion should be among the methods considered.

The Statewide Health Coordinating Council could be used to make an advisory review of all health-related state programs. The Council should have necessary access to information and be required to obtain public input in order to provide state government with an analysis that would identify priority needs and rational allocation of resources. New state initiatives such as alcohol programs for youth and revisions in the state's role in health promotion and education should be evaluated by this process and compared with other needed services before they are funded or implemented.

A major factor in the success of all health care cost containment actions is the response of physicians. Physician participation in the design of such actions and especially in their implementation is critical. This kind of participation should be formally established through some means. One possible approach would be through the Governor requesting the Montana Medical Association to appoint physicians to serve on a committee with the Directors of the Department of Health and Environmental Sciences, Social and Rehabilitation Services, and Institutions to design and implement a program to educate and involve Montana physicians in health care cost containment.

The implementation of the above measures for health care cost containment and resource allocation should enable Montana to meet current and future challenges in health care financing. Specifically, these measures should prevent loss of control of state health expenditures or loss of needed services or access to services by some segments of the population. These recommendations also provide approaches that are flexible enough to remain effective with changing health care needs and resources.

Figure 1




SOURCE: Health Care Financing Review, September 1981.

Table 1
NURSING HOME BEDS AND PROJECTED NEEDS – MONTANA

| Service Area | Beds 1981 | Bed Need 1985 | Deficit (-) Surplus (+) |
|---|---|---|---|
| Eastern | 990 | 955 | 35 + |
| North Central | 1,108 | 1,127 | 19 - |
| South Central | 1,059 | 1,162 | 103 - |
| Southwestern | 1,514 | 1,501 | 13 + |
| Northwestern | 1,302 | 1,351 | 49 - |
| STATE | 5,973 | 6,096 | 168 - |

SOURCE: Department of Health and Environmental Sciences, Bureau of Health Planning and Resource Development, Licensing List and Outstanding Certificates of Need.

Table 2
STATE OPERATED LONG TERM CARE SERVICES – MONTANA

| Institution | Planning Regions | Beds |
|---|---|---|
| Eastmont Human Services | I | 55 |
| Warm Springs State Hospital | IV | 64 |
| Montana Center for the Aged | III | 199 |
| Montana Veterans Home | V | 40 |
| Boulder River School & Hospital | IV | 242 |
| Galen State Hospital | IV | 185 |
| TOTAL | | 785 |

SOURCE: Department of Health and Environmental Sciences, Bureau of Health Planning and Resource Development, Montana 1980 Medical Facilities Annual Report.

Table 3
ESTIMATES OF NEED FOR NON-INSTITUTIONAL LONG TERM CARE SERVICES

SOCIAL SERVICES

| Service[1] | 1983 Clients | 1983 Budget |
|---|---|---|
| Case Management (DD) | 1,641 | $ 318,821 |
| Adult Foster Care | 1,200 | 208,210 |
| Homemaker | 2,400 | 741,749 |
| Institutional Placement | 1,800 | 305,809 |
| Daily Living Training (DD) | 562 | 2,791,185 |
| TOTAL | 7,603 | $4,365,774 |

AGING SERVICES

| Service | 1983 Clients | 1983 Budget |
|---|---|---|
| Region I | | |
| Home Health | 826 | $ 83,643 |
| Home Chore | 826 | 15,071 |
| Home Delivered Meals | 300 | 163,655 |
| SUBTOTAL | 1,952 | $262,369 |
| Region II | | |
| Home Chore | 120 | $15,109 |
| Home Delivered Meals | 1,500 | 72,297 |
| Homemaker | 100 | 12,524 |
| SUBTOTAL | 1,720 | $99,930 |
| Region III | | |
| Homemaker | 1,975 | $ 46,391 |
| Home Chore | 1,975 | 17,761 |
| Home Delivered Meals | 4,000 | 46,687 |
| SUBTOTAL | 7,950 | $110,839 |
| Region IV | | |
| Homemaker | 3,500 | $ 33,695 |
| Home Health Aide | - - | 71,258 |
| Home Delivered Meals | 1,000 | 199,218 |
| SUBTOTAL | 4,500 | $304,171 |
| Region V | | |
| Homemaker Chore | 639 | $ 87,268 |
| Home Health | 296 | 39,763 |
| Home Delivered Meals | 664 | 108,624 |
| SUBTOTAL | 1,599 | $235,655 |
| TOTAL | 17,921 | $1,012,964 |
| Service to the Blind - (FY 1980) | | |
| Severly Disabled (Blind) | 321 | $255,000 |

[1]See Appendix A for service definitions.

[2]Regions presented are the Governor's Planning Regions. The Aging Services regions fit into these except the six Indian Reservations east of the Continental Divide which are considered a separate region by Aging Services.

SOURCE: Montana Department of Social and Rehabilitation Services, Montana Proposed Human Social Services Plan for Title XX, July 1, 1981 through June 30, 1983; Aging Services - Annual Plans for Area Agencies on Aging, 1980; Blind Services-Department of Social and Rehabilitation Services, Program and Financial Plan for Vocational Rehabilitation Agencies, 1979.

Table 4

PERSONAL HEALTH CARE EXPENDITURES BY SELECTED SOURCES OF FUNDS, 1979

| Source of Payment | Total | Hospital Care | Physicians Services | Dentists Services | Other Professional Services | Drugs & Medical Sundries | Eyeglasses & Appliances | Nursing Home Care | Other Health Services |
|---|---|---|---|---|---|---|---|---|---|
| | Percentage Distribution | | | | | | | | |
| Total | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| Direct Payments | 31.8 | 8.1 | 36.5 | 73.0 | 60.4 | 83.7 | 87.0 | 42.0 | - - |
| Third-Party Payments | 68.2 | 91.9 | 63.5 | 27.0 | 39.6 | 16.3 | 13.0 | 58.0 | 100.0 |
| Private Health Insurance | 26.7 | 34.9 | 37.3 | 23.0 | 12.9 | 7.9 | 3.6 | .7 | - - |
| Philanthropy and Industrial In-Plant | 1.3 | 1.1 | .1 | - - | 1.1 | - - | - - | .6 | 24.8 |
| Government | 40.2 | 55.9 | 26.2 | 4.0 | 25.6 | 8.4 | 9.4 | 56.7 | 75.2 |
| Federal | 28.3 | 40.9 | 19.7 | 2.2 | 18.1 | 4.2 | 7.6 | 30.7 | 53.7 |
| Medicare | 15.6 | 25.4 | 15.8 | - - | 11.8 | - - | 5.7 | 2.1 | 1.9 |
| Medicaid | 6.2 | 5.1 | 3.0 | 1.8 | 5.3 | 3.9 | - - | 26.8 | 5.5 |
| Other | 6.5 | 10.4 | 1.0 | .4 | 1.0 | .2 | 1.9 | 1.8 | 46.3 |
| State and Local | 12.0 | 15.0 | 6.5 | 1.8 | 7.5 | 4.2 | 1.8 | 26.1 | 21.5 |
| Medicaid | 5.3 | 4.3 | 2.5 | 1.5 | 4.5 | 3.3 | - - | 22.6 | 4.6 |
| Other | 6.7 | 10.7 | 4.0 | .3 | 3.0 | .9 | 1.8 | 3.5 | 16.9 |

SOURCE: "National Health Expenditures, 1979," Health Care Financing Review, Summer, 1980

Table 5

## HEALTH CARE EXPENDITURES BY TYPE OF EXPENDITURE 1980 – MONTANA

| Hospital | Total Dollars | Percent | National Distribution |
|---|---|---|---|
| Private | 196,813,309 | 33.3 | |
| Federal | 20,068,491 | 3.4 | |
| State | 11,930,939 | 2.0 | |
| Total | 228,812,739 | 38.7 | 40.2[1] |
| Long Term Care | | | |
| Private | 59,490,108 | 10.1 | |
| State | 14,921,423 | 2.5 | |
| Home Health | 1,769,307 | .3 | |
| Total | 76,180,838 | 12.9 | 8.4 |
| Personnel | | | |
| Physicians | 70,771,811 | 11.9 | 19.1 |
| Dentists | 34,303,920 | 5.8 | 6.4 |
| Other | 16,013,822 | 2.7 | 2.2 |
| Total | 121,089,553 | 20.5 | 27.7 |
| Pharmaceutical | 35,491,738 | 6.0 | 8.0 |
| Gov. Public Hlth | 68,552,776 | 11.6 | 2.9[2] |
| Eyeglasses | 15,214,585 | 2.5 | 2.1 |
| Prepayment Expen. | 26,991,334 | 4.6 | 3.6 |
| Research/Const. | | | 4.7[3] |
| Other Health | 18,109,604 | 3.1 | 2.4 |
| FINAL TOTAL | 590,443,167 | 100.0 | 100.0 |
| State Per Capita | 751.00 | U.S. Per Capita | 943.00 |

[1]National Hospital Expenditures include some long term care expenses.

[2]Government Public Health Expenditures for Montana and the United States are not comparable.

[3]Montana figures for research and construction are included in Government Public Health.

1980 Montana Population: 786,690

SOURCE: Department of Health and Environmental Sciences, Bureau of Health Planning and Resource Development, Montana Health Care Expenditures By Type of Expenditure - 1980.

Figure 2
MEDICARE-MEDICAID EXPENDITURES – MONTANA 1977-1981


SOURCE: Medicare information from Health Care Financing Administration, Denver Regional Office; Medicaid information from Budget Office, State of Montana.